WORLD CHRONICLE

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PROGRAMME: "WORLD CHRONICLE"

GUEST: Lowell Levin, Member
Expert Committee on Information and Education for Health
World Health Organization (WHO)

JOURNALISTS: Ethan Schwartz, Washington Post
Raghida Dergham, Al-Hayat, London
Ian Steele, Press Foundation of Asia

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SYNOPSIS

Lowell Levin, Professor of Public Health at the Yale of School Medicine and Member of the World Health Organization's Expert Committee on Information and Education for Health, discusses the increasing number of non-communicable diseases which are caused by unhealthy lifestyles. At present, as much as 70% of deaths in developed countries and 40% in developing countries are the result of man-induced non-communicable diseases.

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VOICE From United Nations Headquarters in New York, this is **World Chronicle**, an uneconomical interview programme about major global issues. Here now to introduce our guest is the host of today's **World Chronicle**.

TOOMBS: Hello, I'm Bob Toombs and this is **World Chronicle**.

Can lifestyle cause life threatening diseases? According to WHO, the World Health Organization, the answer is yes. In fact, recent studies indicate that 70 percent of deaths in developed countries and 40 percent in developing countries are caused by choice of lifestyles, notably by too much fatty food, salt, alcohol, by tobacco, by a lack of exercise, and by polluted environments.

Our quest today, Lowell Levin of the United States, is Professor of Public Health at the Yale School of Medicine. He also serves as a member of the World Health Organization's Expert Committee on Information and Education in Health. Prof. Levin will be interviewed here at the United Nations Headquarters in New York by: Ethan Schwartz of the Washington Post, Raghida Dergham of Al-Hayat, an Arabic daily of London; and Ian Steele of the Press Foundation of Asia.

Prof. Levin welcome to **WORLD CHRONICLE**.

TOOMBS: As I understand it the key to the diseases that we are talking about are called non-communicable diseases as opposed to communicable diseases. I've never heard that term before. What does non-communicable disease mean?

LEVIN: A non-communicable disease is essentially a disease which does not involve infectious agents like a vector, like a germ, like a micro organism. It is a disease which is basically not transmittable between two individuals, or in a community.

TOOMBS: Give me an example?

LEVIN: A disease like diabetes is usually derived from the kinds of genetic and behaviourial aspects of a person's life, not usually, always derived from those and associated factors rather than a micro organism.

TOOMBS: So things like smoking or drinking?

LEVIN: Yes. Smoking and drinking, not in the case of diabetes, but certainly smoking and drinking and saturated fats, eating animal fats in effect, all of these things -- and lack of exercise of course -- all of these things contribute to what we call non-communicable diseases.

SCHWARTZ: Prof. I understand there's a rather unique link between non-communicable diseases or the instance of non-communicable diseases and a rise in wealth in a country. One would think it might be the opposite. How has this link been establish and are there any examples of countries or regions where things like heart attacks, diabetes and so forth have actually risen with wealth rather than decreased?

LEVIN: Oh, yes. Japan is an example and there are many countries in the Asian group that are good examples or bad examples if you wish. Modernization has its blessings, it also has its downside. With modernization and industrialization come a sedentary lifestyle, comes the eating of foods which are

prepared and sold in supermarkets that have a lot of salt, a lot of fat, animal fat, a lot of sugar. These things were never part of the natural diet, if you will, or the ordinary native diet of many of the countries of the world. These have been introduced through the so-called modernization process.

SCHWARTZ: But how have you isolated these changing lifestyles so that you're certain that they are the causes of the diseases? In other words, is there a chance that simply as life expectancy goes up people live longer so more people die of heart attacks rather than diseases that they might have died of at an earlier age?

LEVIN: Of course the latter is true. The older you live the more likelihood it is that you'll be dying from a non-communicable disease, a lifestyle oriented disease but we have had examples of countries in this world, developing countries in this world, that never knew these diseases, so-called non-communicable diseases, until modernization and we have seen the effects of this modernization on the population as a whole. The introduction of cigarette smoking for example is a very dramatic example of what so-called modernization can do to a population that heretofore was protected from that kind of assault.

DERGHAM: This, however, does not deny the fact that not everybody has the luxury of choosing a lifestyle. If I may give two examples, apparently there has been a recent study in which it was concluded that a man in Harlem, New York, lives shorter than a man in Bangladesh and secondly, there is the element of politics of the industries. Can you address these two points, the politics of the industry and the lack of choice, the luxury of lifestyle?

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LEVIN: You are absolutely right. It's very easy to sit here and say to people, "Don't eat this, don't drink that, don't smoke this" and say, "Well, now we've told them and that will be that". They'll immediately change their behavior. But for many people the healthy choice is not the easy choice. They don't have access to the kinds of foods at low cost that are nutritious. They are under substantial peer pressure to conform to certain lifestyle behaviours that are not in their health interest. There is no doubt that people do not operate as atoms, they operate in collectives and society has to carry responsibility for supporting the development of healthy lifestyles.

DERGHAM: The point of politics. Let's say certain industries want to make sure that their products are well sold, well marketed. There is an issue of distrust in a sense but we are also being taken for a ride. One day we are told oatmeal is wonderful for you the next day we are told, oh no, not really, so how do we as individuals figure in the politics of the industries and the marketing of certain products?

LEVIN: There are two issues that you raise. The last one is, how can we believe every announcement every other day which contradicts the announcement on the previous day with regard to what is good for you and what is bad for you. I think we have to appreciate that so-called health facts have a half life of about four years. Things do change. As scientists inquire more deeply into issues they discover deeper truths but there are some things that are beginning to withstand or hold the test of time. Certainly, the lack of exercise is an absolutely key factor and that has stood the research efforts of many decades now. The same is true for smoking, cigarette smoking in particular. The same is probably true for the animal fat issue. I say probably because there is still some

controversy around some of these lifestyle factors but in the main we're beginning to get a handle on the main ones. Now, with regard to the politics, yes. I mean we do have a problem and you said something about not trusting. I think one of the important things in lifestyle is for people to understand that they have to take charge of their health status and part of that taking charge is to realize the economic and political implications of what is happening. Yes, there are commercial interests in selling products, yes there are governments that look the other way from time to time because of the economic benefits of importing certain products -- alcohol and refined sugar and wheat and other products -- where the local products are not being used as much as they should, corn versus wheat for example. So there are many political issues involved.

STEELE: What is the World Health Organization doing to help nations and people take charge of their lifestyle?

LEVIN: The World Health Organization, which is a specialized agency of the United Nations, has for the last decade at least, the last decade perhaps even longer, begun to put into place a programme that is health promotive by saying lifestyle is very important, but remember lifestyle has to be within the context of the social and political realities of countries and that we are in effect one world and the health of the individual is very much affected by the behavior of people quite distant from where they live.

STEELE: If I could take up that distance issue, food companies who are quite distant from the people they feed. Is WHO talking to the people or is it also talking to the companies?

LEVIN: Oh, it's talking to the companies as well. It's talking to pharmaceutical companies, we know all about that. They are talking to food manufacturers and distributors. The tobacco industry, we know the story there. Talk is one step, but there has to be something else and that is the political will at the country level to make sure that individual countries support the lifestyle behavior changes they are interested in by enacting legislation or carefully labelling foods or whatever it takes to help individuals and families undertake changes in their lifestyles. It can't be done by individuals alone.

STEELE: Is there any evidence that governments are listening to you in the developing world with regard to labelling of cigarettes, labelling of food products?

LEVIN: Yes. I think there are definitely signs that the developing world is. First of all, of course they are aware of this problem and there are signs that they are taking action, but it has to understood that this is not a simple matter. Taking action internationally means that many countries are faced with economic crises as a consequence of taking an action. There is no such thing as an isolated health action. If you take action against the international agricultural business you have to pay the consequences in some other area, tax income for one. So it is a complex problem but governments are aware and they are, where they can, making moves to support lifestyle changes in individuals.

TOOMBS: How has the communications explosion -- film, television, video cassettes -- how have these affected the lifestyles of the developing countries?

LEVIN: Oh, Bob it's good news and it's bad news. The good news is, of course, media have played an important role in acquainting the public with the risks they run. It provides a lot of very good, timely information but at the same time it creates an image around certain products and sells them with the so-called hard sell. This results in many people opting for these products and services which are not in their best health interest.

TOOMBS: How would you respond to a hedonist who says to you, "Hey, you're trying to take all the fun out of life"?

LEVIN: Well, it depends on how much fun he wants and how much life he wants. I think that one can have a good, happy, healthy life. A healthy life need not be a life that is miserable. You can enjoy good foods and good company without running the kinds of excessive risks that we now run in a developed world and we hope in the developing world they can avoid the problems that my country has been suffering from for many years.

SCHWARTZ: I'm curious. Is this only a question of modernization or is this an issue of cultural influence as well? To take one example, has research shown let's say to take Japan since you mentioned it. Is a man who eats a wealthier or a woman who eats a wealthier Japanese diet is she also more at risk or is it because they make the switch to a Western diet that they're more at risk and I'm curious along those lines if any research has been done into the diets of various regions in the world which are healthier and what lessons can be learned across boundaries or across cultural boundaries?

LEVIN: The latter part of your question yes, there is a substantial amount of both medical, anthropological research and epidemiologic research, studies of diseases and health behaviours in large populations, that demonstrate that we have in the developed world much to learn from a developing world. You know it's always been perceived as the other way around, the developed world has a lot to offer the developing world. That may be true in some instances of technology but it's also true that the developing world, having a food lifestyle as it were low in saturated fats, low in alcohol consumption, no cigarette smoking, these lifestyle lessons can be learned and should be learned and are being learned by the developed world. Now, the first part of your question.

SCHWARTZ: Well, I'm curious. Is it only a question of people becoming rich or there are some cultures which are fairly developed such as Japan but where for whatever reason the lifestyle is actually healthier?

LEVIN: I think they go hand in hand. Of course with increased economic options people will choose, make choices that may not always be in their best health interest simply because they have those choices. There is a certain amount of cultural barrier to doing things that run against beliefs that are deeply held with regard to food preferences for example but by and large I think economic growth is the main culprit because of the spread of choices and particularly the convenience implications of those choices.

TOOMBS: The programme is **WORLD CHRONICLE.** Our guest is Lowell Levin, Professor of Public Health at the Yale School of Medicine and a member of the World Health Organization's Expert Committee on Information and Education for Health.

TOOMBS: Is any scientific breakthrough required to deal with and treat non-communicable diseases?

LEVIN: Well, that is the wonderful thing Bob, about this problem. This we can solve. This is within grasp. This is what every individual, family, community and nation can undertake to do right now within the bounds of our known technology. It is not a hightech issue. It doesn't require a lot of machinery and wheels and dials. It requires knowing about what the risks are that you are running, knowing what you can do about it personally and socially or politically, and taking the action with yourself, your family and your neighbours. It is within our grasp. That's what makes it such an attractive possibility and why the World Health Organization is so excited about moving on this now.

DERGHAM: You're going to have difficulty with me Doctor. Forgive me, because I'm one of those who resist this whole line of watch out what you eat, do this, don't do that. I mean after all when I would have a piece of meat how would I know if it's been injected by hormones that are no good for the cattle that finally may give me X disease, that maybe that's the reason why the Europeans are not importing their meat from the United States? How am I to know? What am I in this whole formula but one person who probably is hungry for a piece of meat?

LEVIN: But you're not one person, you're many people. Collective action is what we need. You are absolutely right that an individual can't on their own x-ray a piece of meat or test it chemically to determine its quality, whether it has additives or not, but you, collectively with your friends and neighbours, can make demands on your governments to make sure that that food is inspected and that food is labelled so that you can make an intelligent choice whether you want it or you don't want it.

DERGHAM: Doctor, isn't it easier for me to just say, listen I can't declare myself a fighter on every single piece of food I eat or drink I drink so let it be. Let me be back to my good old culture as a Lebanese, fatalistic and say, when it's my day I'll go? How would I be able to fight let's say Con Edison with whatever projects they have which are supposedly for the improvement of my lifestyle yet there are certain things as a result of projects of Con Edison that kill me everyday so why am I going to take people to task simply because they smoke a cigarette?

LEVIN: Well, not everyone has the political interest, or the time, or the talent to undertake what I've just proposed but on the other hand there are many examples where communities have rallied together, pulled themselves together and have made a powerful difference. Take for example the anti-smoking campaigns in the Western countries, and in the United States in particular, where there was very little interest in government to do anything about smoking, very little. People, ordinary people, said we've had enough. We're going to band together and take advantage of the political opportunities, helped by the media I might add who came to them and showed them as militant people who are not going to tolerate any longer their civil rights being abused by others. And so that movement grew and now you see the policies coming.

DERGHAM: But is that fair? What about the rights of the smoker? Is that fair to impose the will of a certain people only because there may be, and it's a may be, a reflection on their health?

LEVIN: Well, I don't know how one defines fairness. The first civil right is that every individual has a right of access to a healthful environment. Everyone has that

right. If you choose to smoke in the privacy of your own home that's up to you but I think when you're in the company of others, particularly people that aren't related to you, not even friends, we have as social beings an obligation to protect the health rights of others.

STEELE: I think we're largely talking about people who have choices, people in countries like this, what about the people in the developing world who have no choices for the very basic reason that they can't read or write, that they have no communication, that they have no possibility of control, people power as you suggested to Raghida? What about that 40-50 percent figure which is going to grow very fast, the 50 percent of deaths attributable to non-communicable diseases in the Third World? How is WHO going to address that issue at the level of education, at the level of government, at the level of supply through the corporations and others?

LEVIN: The World Health Organization is putting its money on the idea that political action, community organization, working at the community level is the way to go. By organizing people around health issues as political issues, not health issues as some airy fairy detached concerned but something that is central to the life and times of people, they're putting their effort there saying we have to organize at the community level. In this country by the way, that is the U.S., there are many parts of this country which are like the developing world where a lot of people don't have any more chance of a healthy life than people in the most impoverished of the developing world, and we have seen there how they can be exploited and we have seen there how having no choices reduces them to behaviours which are literally killing them and the only way to go as far as I'm concerned, and I believe WHO agrees, is to organize at the community level. Without organization,

without participation of citizens in this process, the likelihood of governments responding favourably is diminished substantially.

STEELE: One of the inevitabilities of this question is ultimately a restructuring of health care. We're seeing it in the United Stated and in Europe and in other developed countries. How will the developing world accommodate a restructuring when in effect there is already no infrastructure for health or very limited infrastructure for health? We're talking about a new blueprint for the health care of the developing world.

LEVIN: Yes. I think that the World Health Organization is beginning to give more emphasis to what we call "upstream effort" and designing a health system, not a health care system but a health system, a system which addresses prevention and health promotion in the main. You see what we've done in the Third World or in the developing world and in this country, and countries like it is that we've put most of our money where there is least benefit -- downstream. We've put it into hightech medical care. Very little, about two percent of the United States' investment in so-called health goes into investments into disease, disease cure, disease treatment. We can reverse that and I think that the developing nations of our world have a chance when they form their new infrastructures to put their emphasis where it belongs, on prevention and health promotion. That takes courage but they have an opportunity that many developed countries don't have because we have long traditions and major investments in the hightech, downstream efforts of curative medicine. It's going to be hard to reverse that in my country.

STEELE: Could you prioritize the areas most needing attention at the present time? Are we looking at the Western Pacific, the Pacific Rim, Asia in the first instance, Latin America, then Africa? What is the order of priority and who is most at risk at this particular time?

LEVIN: It's hard to give that a very simple answer. My own personal priority is the African countries would be on my priority list at the top.

STEELE: You think they're not rapidly developing in the same way as Asia? Why is that? Why would you give them the priority?

LEVIN: Why their economic development has not kept up with Asian development is a subject we could go on at length on and I am not an expert economist and I couldn't give you a good answer there. I think there is a long history of colonial enterprise in Africa which has created certain problems for African national development and the health development is part of that, but there are a lot of African countries that are well aware of the possibilities and are seeking WHO's assistance and UNICEF's assistance in developing a strategy which has this health promotive orientation.

STEELE: So they are most at risk, the African countries?

LEVIN: I would say they are at great risk. Whether they are most or not is debatable. I would put them way up the top.

STEELE: Is that in part because they are perhaps least able to defend their position?

LEVIN: No, I think that as I indicated that a long history of colonial development in inverted commas, "colonial development", probably accounts for some of the failure to achieve a level of structure that we have seen in Asia for example but that can and will change rapidly as countries develop a more powerful economic base.

SCHWARTZ: Prof., who are the best and the worst in the developed world? In other words, is there a kind of a blissful model country where nobody smokes, nobody eats fatty meats, everybody exercises and practices safe sex and everybody lives till 90? Who would be the best country to emulate in this case?

LEVIN: Well, some people might answer the Nordic countries.

SCHWARTZ: Don't the Finns eat a lot of meat though?

LEVIN: Yes they do, but they've cut down since the national government established a national, federal policy saying we are going to put a stop to some of the things government is contributing to the problem. Now, they're not telling people they can't eat this or can't drink that but they are at least protecting the public from advertising and marketing strategies which are insidious. That, at least, they are doing and are taking some very positive steps by saying we have some alternative strategies which are safe, effective and fun. Happy alternatives that you can enjoy life, you can feel better and you can do a lot of things you couldn't do before if you follow this particular line of lifestyle. I would say the Nordic countries probably are most people's examples of countries with substantially healthy lifestyles and I want to say something about Nordic countries before I finish that question. One other thing that you have to say, they are a happy people.

SCHWARTZ: Don't the Swedes have one of the highest suicide rates in the world? I thought that was one ...

LEVIN: Well, having a high suicide rate I wouldn't say is an indication of happiness or unhappiness in a country.

SCHWARTZ: It's an indication of something.

LEVIN: It has other diseases. Suicide rates can't be justified as an indication of major ill health in a country.

DERGHAM: The lifestyle of the rich and famous is something that attracts people's attention how about the lifestyle of the poor, the overworked, the miserable, those who can't afford the choice of saying, well I'll give an hour for an exercise gym today or I will eat X amount of materials? So what do you do for them? What does the World Health Organization do for those people with no choice?

LEVIN: The World Health Organization you know is an advisory group. It can't go into a country and rearrange the furniture. You can't rearrange a country's priorities, you can't tell them in effect what they should do or not do. They can advise. They can support technically, they can provide examples from other countries, but it will take ultimately the political will of a particular country to make the difference. Now, that is a big order for some countries who are preoccupied with war, internal strife and civil strife, civil war, pressures of enormous consequence in their economy. They have a lot of things on their agenda and health unfortunately, in many cases, cannot take the top priority but we know that an unhealthy population is a non-productive population and it's an insidious situation. Poor health creates lower productivity, lower productivity affects the economic growth rate and the like.

TOOMBS: Prof. Levin, that's all the time we have. Thank you for joining us on this edition of **WORLD CHRONICLE**.

Our guest has been Professor Lowell Levin, member of the World Health Organization's Expert Committee on Information and Education for Health. He was interviewed here at United Nations Headquarters in New York by: Ethan Schwartz of the Washington Post; Raghida Dergham of Al-Hayat, an Arabic daily of London; and by Ian Steele of the Press Foundation of Asia.

I'm Bob Toombs. Thank you for joining us and we invite you to be with us for the next edition of **WORLD CHRONICLE**.

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